IN THE UNITED STATES DISTRICT COURT
FOR THE NORTHERN DISTRICT OF MISSISSIPPI
WESTERN DIVISION

STACY D. MAGEE, ET AL PLAINTIFFS

VS. CIVIL ACTION NO. 3:00CV218-B-A

BENMARK, INC. ET AL DEFENDANTS

MEMORANDUM OPINION

This cause comes before the court on the motion for summary judgment and motion to strike filed by defendant North Mississippi Physicians Association, LLC ["North Mississippi"] and the separate motion for summary judgment filed by defendant Benmark, Inc. ["Benmark"]. Upon due consideration of the parties' memoranda and exhibits, the court is ready to rule.

FACTS

On July 28, 1998, the plaintiff, Stacy Magee, an employee of Oxford OB-GYN Associates, enrolled in the North Mississippi Physicians Association Employee Medical Benefit Plan ["Plan"] offered by her employer. Upon enrollment, she listed her husband, Walter Magee, and her two stepchildren, Brennan and Macy Magee, as family members to be covered under the Plan and began paying the premiums for medical coverage of her family. Thereafter, on at least two separate occasions, Stacy Magee filed medical benefits claims on behalf of Brennan and Macy Magee to Benmark, which was responsible for the initial processing of all claims under the Plan. On each of these occasions, Benmark paid the medical benefits claims and sent a letter to Stacy Magee, verifying her children's coverage.

On or about April 28, 2000, Brennan and Macy Magee sustained injuries from a motor vehicle accident and incurred medical expenses. Stacy Magee submitted medical benefits claims on behalf of her stepchildren and received separate phone calls from North Mississippi and Benmark,

asking her questions about the stepchildren. Stacy Magee alleges that a North Mississippi representative assured her that the plan would cover the children's medical expenses. However, on August 9, 2000, Stacy Magee received a letter from Benmark denying coverage of her stepchildren's medical expenses on the basis that they did not qualify as "eligible dependents" as defined under the policy. Stacy Magee appealed Benmark's denial of benefits to the Insurance Committee of North Mississippi ["Insurance Committee"], as instructed under the Plan. On November 16, 2000, the Insurance Committee affirmed Benmark's denial of the claims based on the determination that Brennan and Macey Magee failed to meet the criteria for "eligible dependents" under the policy.

The plaintiffs subsequently brought this action, alleging denial of benefits in violation of ERISA and equitable estoppel based on federal law and state law claims of negligent misrepresentation, bad faith, and unfair competition and practice in violation of Miss. Code Ann. § 83-5-35(a).

LAW

A. Motion for Summary Judgment

On a motion for summary judgment, the movant has the initial burden of showing the absence of a genuine issue of material fact. Celotex Corp. v. Catrett, 477 U.S. 317, 325, 91 L. Ed. 2d 265, 275 (1986) ("the burden on the moving party may be discharged by 'showing'...that there is an absence of evidence to support the non-moving party's case"). Under Rule 56(e) of the Federal Rules of Civil Procedure, the burden shifts to the non-movant to "go beyond the pleadings and by...affidavits, or by the 'depositions, answers to interrogatories, and admissions on file,' designate 'specific facts showing that there is a genuine issue for trial.'" Celotex Corp., 477 U.S. at 324, 91 L. Ed. 2d at 274. That burden is not discharged by "mere allegations or denials." Fed. R. Civ. P. 56(e). All legitimate factual inferences must be made in favor of the non-movant. Anderson v. Liberty Lobby, Inc., 477 U.S. 242, 255, 91 L. Ed. 2d 202, 216 (1986). Rule 56(c) mandates the entry of summary judgment "against a party who fails to make a showing sufficient to establish the existence of an element essential to that party's case, and on which that party will bear the burden of proof at trial." Celotex Corp., 477 U.S. at 322, 91 L. Ed. 2d at 273. Before finding that no genuine issue for trial

exists, the court must first be satisfied that no reasonable trier of fact could find for the non-movant. Matsushita Elec. Indus. v. Zenith Radio Corp., 475 U.S. 574, 587, 89 L. Ed. 2d 538, 552 (1986).

1. Claim for denial of benefits

The Employee Retirement Income Security Act, ERISA, clearly governs this cause. A denial of benefits challenged under § 502(a)(1)(B) of ERISA, 29 U.S.C. § 1132(a)(1)(B), is reviewed under a de novo standard unless the plan gives the administrator "discretionary authority to determine eligibility for benefits or to construe the terms of the plan." Firestone Tire & Rubber Co. v. Bruch, 489 U.S. 101, 115, 103 L.Ed.2d 80, 95 (1989). When a plan administrator has discretionary authority with respect to the decision at issue, the appropriate standard of review is one of abuse of discretion. Id. However, if the administrator has a conflict of interest, the existence of the conflict is a factor to be considered in determining whether the administrator abused its discretion in denying a claim. Vega v. National Life Insurance Services, Inc., 188 F.3d 287, 297 (5th Cir. 1999). It is undisputed that North Mississippi, the plan administrator, had discretionary authority with respect to the decision at issue. It is also undisputed that the Insurance Committee had a conflict of interest in reviewing Benmark's decision. Accordingly, the court reviews the Insurance Committee's denial of Stacy Magee's medical benefits claims under an abuse of discretion standard while taking into consideration the Committee's apparent conflict of interest.

Application of the abuse of discretion standard involves a two-step process. First, a court must determine the legally correct interpretation of the plan. If the administrator did not give the plan the legally correct interpretation, the court must then decide whether the administrator's decision was an abuse of discretion. Wildbur v. Arco Chemical Co., 974 F.2d 631, 637 (5th Cir. 1992). In answering the first question, whether the administrator's interpretation of the plan was legally correct, the court must consider: (1) whether the administrator has given the plan a uniform construction, (2) whether the interpretation is consistent with a fair reading of the plan, and (3) any unanticipated costs resulting from different interpretations of the plan. In determining the second question, whether the administrator's decision constituted an abuse of discretion, the following three factors are important: (1) the internal

consistency of the plan under the administrator's interpretation, (2) any relevant regulations formulated by the appropriate administrative agencies, and (3) the factual background of the determination and any inferences of bad faith. Id. at 638.

The defendants maintain that the Insurance Committee did not abuse its discretion in denying Stacy Magee's medical benefits claims made on behalf of Brennan and Macy Magee because Brennan and Macy Magee did not qualify as "eligible dependents" as that term is defined under the policy. On page 18 of the Summary Plan Description, "eligible dependent" is defined as an "unmarried child (including step-child of either the employee or employee's spouse) who:

(1) is under age 19;
(2) resides in the household of the employee or for whom the employee is legally responsible for providing medical coverage;
(3) is chiefly dependent upon the employee for support;
(4) is eligible to be claimed as a dependent on the most recent federal income tax return of the employee according to the United States Internal Revenue Service.

It is undisputed that Brennan and Macy Magee are under the age of 19 and do not reside with Stacy Magee but live elsewhere with their natural mother, Irene Jones. Thus, in order to qualify as "eligible dependents," it must be shown that Stacy Magee, the employee, is legally responsible for providing the children's medical coverage, that the children are chiefly dependent on her for financial support, and that they are eligible to be claimed as dependents on her most recent income tax return.

The defendants contend that Stacy Magee was not at any point legally responsible for Brennan and Macy Magee's medical insurance coverage because the divorce decree between Walter Magee and Irene Jones expressly holds Walter Magee responsible for providing medical insurance for the children and Irene Jones equally responsible for the balance of medical services not covered by insurance. Thus, according to the defendants, since the children failed to meet this criterion for "eligible dependents," the medical benefits claims made on behalf of Brennan and Macy Magee were properly denied. In their response, the plaintiffs emphasize that "eligible dependent" is initially defined as an "unmarried child including [the] step-child of *either the employee or employee's spouse*" (emphasis

added) and argue that the requirement, "for whom the employee is legally responsible for providing medical coverage," is fairly and reasonably construed to encompass both the employee and the employee's spouse. Under the plaintiffs' interpretation, Walter Magee's legal responsibility under the divorce decree to provide medical insurance for the children would satisfy this criterion. Such a reading, however, contradicts the clear and unambiguous language of the policy, which specifically requires the employee, rather than the employee's spouse, to be legally responsible for the medical coverage of the children. As the defendants correctly observe, there is no evidence in the record establishing that Stacy Magee was under a legal duty to provide her stepchildren with medical insurance, even if she did so in actuality. Under a fair reading of the Plan, Brennan and Stacy Magee fail to satisfy this portion of the definition for "eligible dependents." Accordingly, the court finds that North Mississippi's decision to deny the medical benefits claim is consistent with the legally correct interpretation of the Plan and, therefore, the plaintiffs' ERISA claim for denial of benefits should be dismissed.[1]

The plaintiffs also allege that the defendants are estopped from denying the medical benefits claims based upon a theory of federal or "ERISA" equitable estoppel. *See* Kane v. Aetna Life Insurance, 893 F.2d 1283, 1285 (11th Cir. 1990). The Fifth Circuit, however, has never adopted "ERISA" estoppel and has in fact expressed doubt as to whether a cause of action for estoppel is cognizable under ERISA based upon written statements. McCall v. Burlington Northern/Sante Fe Co., 237 F.3d 506, 513 (5th Cir. 2000). In any event, the court in Kane held that courts may develop a

[1] In their response to the defendants' motion for summary judgment, the plaintiffs focus on the remaining two factors of the inquiry into whether the administrator applied the legally correct interpretation of the plan, i.e., whether the administrator has given the plan a uniform construction and the existence of any unanticipated costs from a different interpretation of the plan. The court finds that, while the nonexistence of unanticipated costs is to be considered under the abuse of discretion standard of review, this factor does not override the plain fact that the Insurance Committee based its decision on the legally correct interpretation of "eligible dependents." As to the plaintiffs' observation that North Mississippi failed to give the Plan a uniform construction, the court addresses this issue hereinafter in the defendants' motion to strike.

body of federal common law of equitable estoppel only when interpretations of ambiguous provisions in the policy are involved. 893 F.2d at 1285. The Insurance Committee's denial of Stacy Magee's medical benefits claims did not involve interpretation of any ambiguity because, as aforementioned, the section in the summary plan description that defines "eligible dependents" is clear and unambiguous. The decision in Kane, therefore, is inapplicable to the case sub judice. Accordingly, the court finds that the plaintiffs' claim for "ERISA" estoppel should be dismissed.[2]

2. State law claims

§ 514(a) of ERISA, the so-called "preemption" clause, provides that ERISA supersedes all state laws insofar as they "relate to any employee benefit plan . . ." 29 U.S.C. § 1144(a). It is well-established that the phrase "relate to" is to be construed broadly, such that state laws "relate to" employee benefit plans whenever they have a "connection with or reference to such a plan." Shaw v. Delta Air Lines, Inc., 463 U.S. 85, 96-97, 77 L.Ed.2d 490, 501 (1983). The Fifth Circuit has found preemption of a plaintiff's state law causes of action whenever two unifying characteristics are present: (1) the state law claims address areas of exclusive federal concern, such as the right to receive benefits under the terms of an ERISA plan; and (2) the claims directly affect the relationship among the traditional ERISA entities–the employer, the plan and its fiduciaries, and the participants and beneficiaries. Memorial Hospital System v. Northbrook Life Insurance Co., 904 F.2d 236, 245 (5th Cir. 1990).

The plaintiffs concede that Stacy Magee's claim for negligent misrepresentation is preempted by ERISA, but assert that the claim brought by Walter Magee as an individual plaintiff should be treated

---

[2] In their complaint, the plaintiffs did not specify whether their claim for equitable estoppel is based on state or federal law. In their response to the defendants' motion for summary judgment, the plaintiffs briefed their equitable estoppel claim exclusively as one based on federal law. In the event the plaintiffs also intended to assert a state-based equitable estoppel claim, the court finds that it is preempted by ERISA. Degan v. Ford Motor Co., 869 F.2d 889, 895 (5th Cir. 1989).

differently because of his distinct status as a third-party, non-ERISA entity. *See* id. The record is clear, however, that Walter Magee was a beneficiary of Stacy Magee's policy and is, therefore, a traditional ERISA entity. Accordingly, the court finds that the plaintiffs' state law claim of negligent misrepresentation is preempted by ERISA. Hermann Hospital v. MEBA Medical & Benefits Plan, 959 F.2d 569, 578 (5th Cir. 1992).

The complaint also alleges violation of Miss. Code Ann. § 83-5-35(a), which deems it an unfair competition and practice to misrepresent the terms of an insurance policy "for the purpose of inducing [a] policyholder to lapse, forfeit, or surrender his insurance." The plaintiffs maintain, implicitly, that this provision is saved from preemption by ERISA's "insurance savings" clause, which exempts from preemption any state law that "regulates insurance." 29 U.S.C. § 1144(b)(2)(A). The Fifth Circuit, however, has held that Miss. Code Ann. § 83-5-35 does not create a cause of action for damages caused by the activity it proscribes; rather, any such cause of action arises only under state common law and is therefore preempted. Perkins v. Time Insurance Co., 898 F.2d 470 (5th Cir. 1990). Accordingly, the court finds that the plaintiffs' claim for unfair competition and practice under Miss. Code Ann. § 83-5-35 is preempted by ERISA.

The complaint also alleges bad faith in denying the medical benefits claims after making representations of coverage. As aforementioned, the Insurance Committee's denial of the subject claims was based on the legally correct interpretation of the provision that defines "eligible dependents." Accordingly, the plaintiffs' claim for bad faith is moot.

B. Motion to strike

In opposition to the defendants' motion for summary judgment, the plaintiffs have submitted the affidavits of Stacy Magee, Jo Lynn Clanton, Bentley Jenkins and Joe Harris in an effort to show that the defendants honored the medical claims of similarly situated employees on separate occasions. Accentuating the uniform construction factor of the abuse of discretion standard of review, the plaintiffs maintain that the court should take into consideration the defendants' inconsistent application of the Plan with respect to the affiants when it determines the legally correct definition of "eligible dependents." The

defendants move to strike the affidavits in their entirety. The court finds that the defendants' motion to strike should be granted as it pertains to all of the affidavits. In any event, even if the affidavits were taken into consideration, the defendants' inconsistent decisions with respect to claims filed by similarly situated employees does not alter the clear and unambiguous language of the provision that defines "eligible dependents."

CONCLUSION

For the foregoing reasons, the court finds that the defendants' motion for summary judgment and motion to strike should be granted. The court also finds that the state law claims should be dismissed with prejudice on the ground of ERISA preemption. An order will issue accordingly.

THIS, the 28th day of August, 2001.

_____

NEAL B. BIGGERS, JR.
SENIOR DISTRICT JUDGE